



Division of
**Health Care
Finance & Administration**

Health Care
Innovation Initiative



Executive Summary

Human Immunodeficiency Virus (HIV) Infection Episode
Corresponds with DBR and Configuration file V1.0

Updated: March 7, 2017

OVERVIEW OF A HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION EPISODE

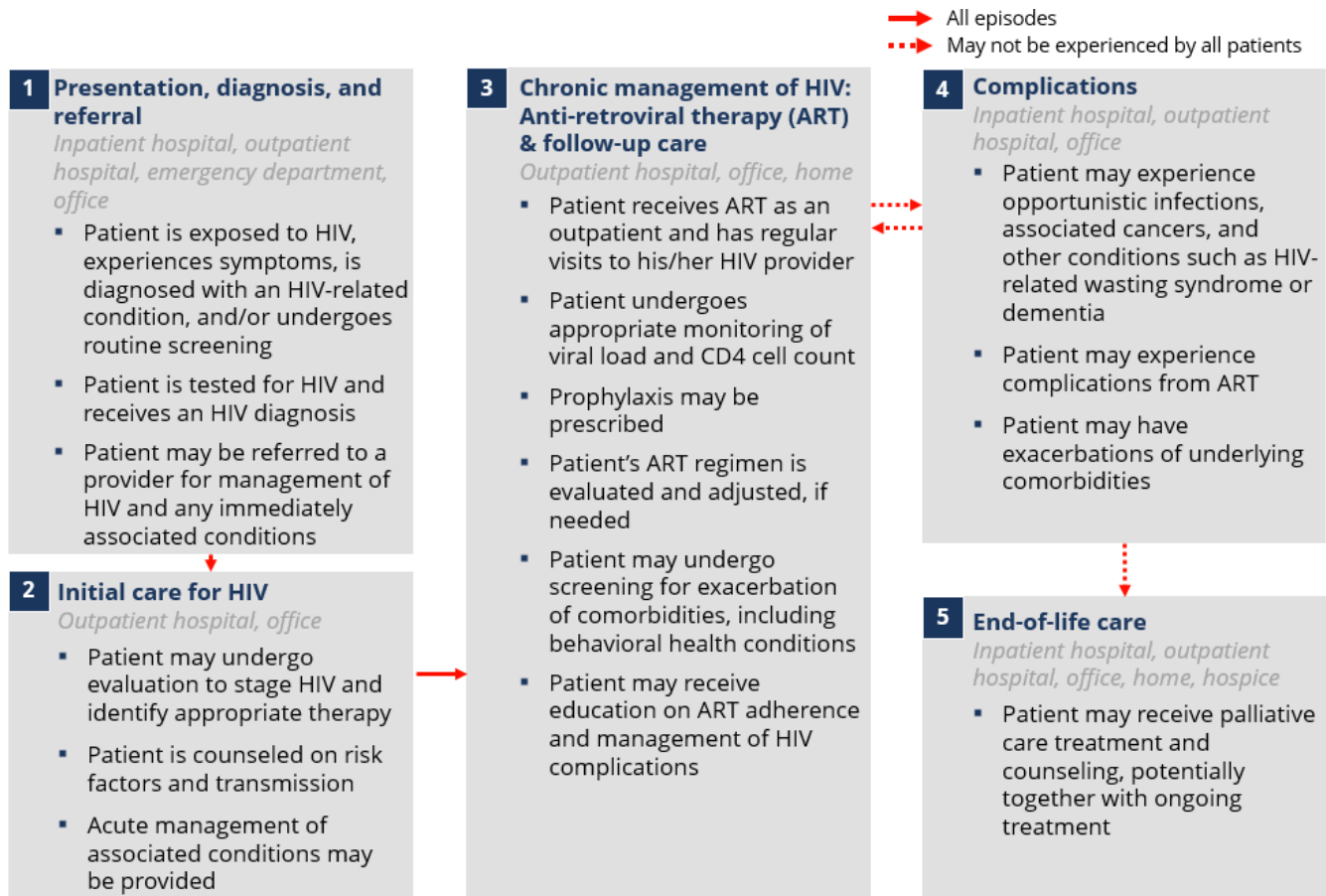
The HIV episode revolves around patients who are receiving anti-retroviral therapy (ART) for HIV. The trigger event is a pharmacy claim with an HIV-specific anti-retroviral therapy (ART) medication. The pharmacy claim must be confirmed by a primary or secondary diagnosis of HIV or an AIDS-defining illness. Related care – such as testing and certain non-ART medications – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the provider with the plurality of related visits. The episode begins on the day of the triggering pharmacy claim and ends 179 days after the triggering pharmacy claim.

CAPTURING SOURCES OF VALUE

Providers have multiple opportunities to improve the quality and cost of care during an HIV episode. Important sources of value include the effective use of assessments and interventions (e.g., testing, screening, administration of prophylaxis) to prevent co-infections and other complications, including those that may lead to emergency department (ED) visits and admissions; as well as the selection of an ART regimen that is compatible with the patient's needs, improves the patient's adherence to ART, and reduces the patient's HIV viral load.

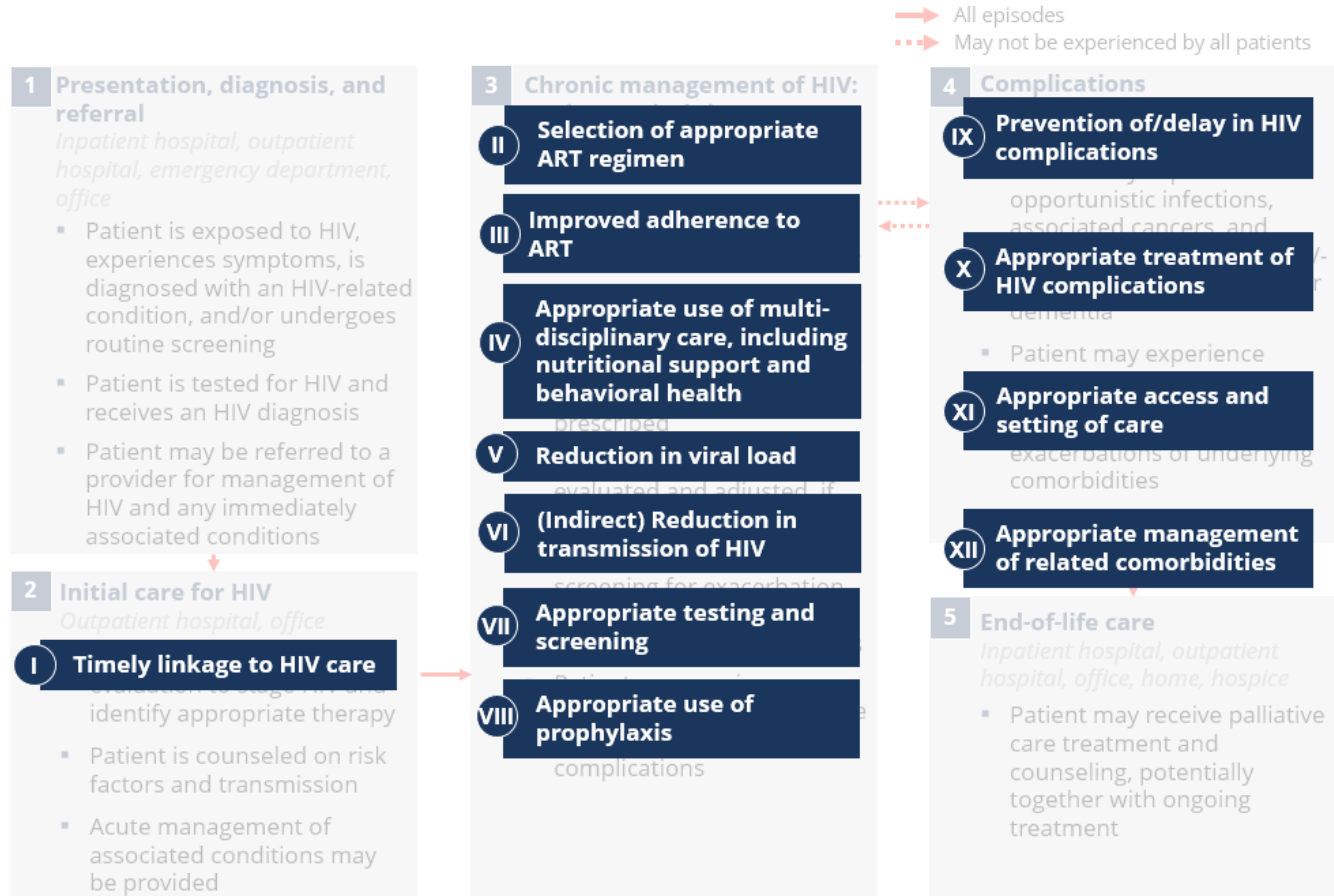
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Illustrative Patient Journey



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Potential Sources of Value



ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the HIV episode, the quarterback is the provider with the plurality of related visits during the episode window and is attributed based on a hierarchy according to the site of the encounter (e.g., non-ED outpatient, ED, and inpatient) and the diagnoses specific to the visit. The contracting entity or tax identification number with the plurality of related visits will be used to identify the quarterback.

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MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Inclusion of only the cost of services and medications that are relevant to the management of HIV in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The HIV episode has no pre-trigger window. The trigger window includes specific relevant care, specific testing, specific medications, and specific surgical and medical procedures. The cost of ART medications is not included in the episode spend. The HIV episode has no post-trigger window.

Some exclusions apply to any type of episode, i.e., are not specific to an HIV episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Examples of exclusion criteria specific to the HIV episode include patients with cardiac arrest or multiple sclerosis. These patients have significantly different clinical courses that the episode does not attempt to risk adjust. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of patient factors likely to lead to the risk adjustment of HIV episodes include depression and respiratory failure. Over time, a payer may adjust risk factors based on new data.

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MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metrics linked to gain sharing for the HIV episode are:

- **Periodic ART refill:** Percentage of valid episodes that have an ART pharmacy claim in at least four of the five defined time intervals during the episode window (higher rate indicative of better performance).
- **Viral status reporting:** Percentage of valid episodes with coding for viral status (higher rate indicative of better performance).

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Infrequent ART refill:** Percentage of valid episodes that have an ART pharmacy claim in none, one, or two of the five defined time intervals during the episode window (lower rate indicative of better performance).
- **New patients:** Percentage of valid episodes where the patient did not have an ART prescription in the 1 year prior to the episode (rate provided for comparison only).
- **Viral suppression:** Of the valid episodes with viral status reporting, percentage of valid episodes with viral load under 200 copies/mL for episodes (higher rate indicative of better performance).
- **Preferred drug use:** Percent of valid episodes where all of the ART medications used during the episode window are on the current Preferred Drug List (PDL) (higher rate indicative of better performance).
- **Hospitalization:** Percentage of valid episodes with one or more HIV-related hospitalization (lower rate indicative of better performance).

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- **ED visit:** Percentage of valid episodes with one or more HIV-related ED visit (lower rate indicative of better performance).
- **Screening for sexually-transmitted infections (STIs):** Of the valid episodes where the patients are 14 years or older, percentage of valid episodes with screening for chlamydia, gonorrhea, or syphilis (higher rate indicative of better performance).
- **Screening for hepatitis C:** Percentage of valid episodes with screening for hepatitis C (higher rate indicative of better performance).

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.